

# RELIASTAR

## Life Conversion Information Request Form

ReliaStar use only

Date received
Date mailed

### Instructions

#### Policyholder (employer)

*This form should be completed and furnished to every employee who has the conversion right.*

#### Employee (person requesting information)

*Complete the employee section and mail to ReliaStar Life at the address shown below within 31 days of the date of termination of group benefits.*

### To be completed by Employer

Group policyholder or plan name		Policy plan number	Account number
Employee's name – Last	First	M.I.	Date of birth
Was employee disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes", give date of disability	Does policy have waiver provision? <input type="checkbox"/> Yes <input type="checkbox"/> No	Was ownership assigned? <input type="checkbox"/> Yes <input type="checkbox"/> No
Initial insurance effective date (with ReliaStar)		Employment termination date	Insurance termination date (DO NOT include grace period)

### Coverage terminating

### Reason for termination

<input type="checkbox"/> Employee Basic Amount .....\$ _____ Supplemental amount.....\$ _____ Other.....\$ _____ <b>Total amount eligible for conversion \$</b> _____ <input type="checkbox"/> Dependent spouse amount .....\$ _____ <input type="checkbox"/> Dependent children (each) .....\$ _____	<input type="checkbox"/> Termination of employment <input type="checkbox"/> Termination of group policy <input type="checkbox"/> Reduction of coverage <input type="checkbox"/> Retirement <input type="checkbox"/> Death of Employee Spouse name _____ <input type="checkbox"/> Other (specify) _____	
This form will be <input type="checkbox"/> handed <input type="checkbox"/> mailed to employee _____ (date)		
Signature (employer)	Title	Company phone number ( ) –

**To be completed by Employee** (do not mail this form to ReliaStar unless the top portion is completed and signed by Employer.)  
Please print clearly.

Requestor's name – Last	First	M.I.	Relationship to employee	Employee SS#:
Home address – Street	City	State	Zip Code	
Signature	Date	Home Phone number ( ) –		

Your Group Insurance Benefits are terminating as indicated above. You may be eligible to convert to an individual whole life policy by **mailing this form within 31 days of such termination.**

Please read the Conversion Right in your group certificate to determine your eligibility. **Complete this form and mail without delay.** ReliaStar Life Insurance Company will send you a description of the conversion plan, premium rates and an application form.

**Important Notice:** This is not an application for conversion of your group life plan coverage. Receipt of this form does not guarantee your eligibility to convert your group coverage.

**IF YOU DO NOT RECEIVE INFORMATION WITHIN 21 DAYS AFTER THE DATE YOU MAILED THIS FORM, PLEASE CALL (800) 955-7736.**

*Please mail to:*

**ReliaStar Life Insurance Company  
Group Conversions, Route 7942  
Box 20  
Minneapolis, Minnesota 55440-0020**

*Do not enclose payment with this form. Send the entire form, when completed, to the above address.*